

Professional Autonomy in Medicine

Defending the Right of Conscience in Health Care Beyond the Right to Religious Freedom

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Abstract

Health-care professionals currently have the right to conscientiously object to any procedure that they deem as morally illicit or that, in their opinion, could harm the patient. However, the right of conscientious refusal in medicine is currently under severe scrutiny. Medical procedures such as abortion and physician-assisted suicide that are not commonly medically indicated, but that can be requested by the patient, represent a type of medical care that is the penultimate expression of patient autonomy. When a health-care provider exercises his or her conscience in a way that denies the patient immediate access to such procedures, many claim that patient autonomy has been oppressed by the religious convictions of the health-care professional. As such, there is a growing opposition to the protection of conscience rights in health care that deserves attention. A common strategy used to defend conscience rights has been to claim that under the United States Bill of Rights, the health-care professional must be allowed to exercise their religious liberties in the context of their profession. This rationale seems to ignite a more intense opposition to conscience

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rights as it seems to validate the sense that a health-care professional's religious convictions are protected at the cost of patient autonomy. This paper reviews the current status of this debate and proposes a defense of conscience rights in health care that considers both the autonomy of the health-care worker and that of the patient in the context of the patient-physician relationship.

Introduction

In his popular TV magazine *What Would You Do?* John Quinones creates ethically and morally troubling situations in public places to record how people react and to find out whether or not those people take action against the portrayed wrong. The essence of this social experiment is to probe the consciences of the average American citizen. When the individuals recorded on the show act out of their personal convictions, both the host and the audience applaud them. As a society, we revere conscience. However, when someone else's conscience runs counter to our own, we no longer applaud his or her sense of duty to self, but call into question the validity of his or her motives. This very scenario is playing out in health care and stands to have a significant impact on the landscape of medicine and the patient-physician relationship.

Health-care professionals currently have the right to conscientiously object to any procedure that they deem as morally illicit or that, in their opinion, could harm the patient. These situations could range from reasonably small issues such as denying a patient's request for a specific prescription (for example, a patient requesting an antibiotic when the physician is sure that the infection is viral) to larger issues such as refusing to participate in or refer a patient for an abortion or assisted suicide. While few would deny the right of the physician to determine the most appropriate medication for the patient's illness, many have called into question the motives of the health-care worker who objects to procedures such as abortion or assisted suicide. It is argued that these procedures represent choices in which the patient should be able to exercise autonomy; an autonomy that should not be oppressed by the convictions of the health-care professional. In response to such arguments, many have maintained that freedom of religion is a constitutional right of the health-care professional; and as such, the professional should not be forced to participate in an act that is counter to their belief system. However, this line of defense leads the opposition to conclude that it is both unprofessional and unconstitutional for the health-care professional to impose their belief system on the patient in a way that limits the patient's liberty. This paper will argue that health-care workers should maintain the right to conscience in their practice of medicine, but not solely on grounds that they have a free right to religion, but, more importantly, that they have the same right to autonomy as the patient. After reviewing the historical context for conscience rights and evaluating the real and present danger to those rights,

this paper aims to show that allowing health-care professionals to exercise their right to conscientious refusal does not limit the liberty of patients, but in fact affirms their personal dignity and autonomy by preserving the integrity of the patient-physician relationship. Since most of the recent debate over the right to conscience in health care centers around conscientious objection to participate in abortion, this paper will focus on that issue as a specific platform to defend the health-care professional's right of conscience.

Past and Present Protection for Right of Conscience

Conscience has long been highly regarded and protected in both U.S. culture and legislation. Our forefathers asserted that conscience should be protected whenever possible. George Washington asserted, "the conscientious scruples of all men should be treated with great delicacy and tenderness: and it is my wish and desire, that the laws may always be extensively accommodated to them, as a due regard for the protection and essential interests of the nation may justify and permit."¹ Thomas Jefferson wrote, "No provision in our Constitution ought to be dearer to man than that which protects the rights of conscience against the enterprises of the civil authority."² Moreover, James Madison argued that the right of conscience is "in its nature an inalienable right."³ More recently, as abortion law was established in the U.S., it is clear that the courts intended that the conscience of medical professionals be protected. While *Roe v. Wade* does not directly address the right of health-care professionals to refuse to participate in abortion procedures, it does give deference to the professional expertise of the physician in designating the physician as the final decision maker.⁴ Interestingly, *Doe v. Bolton*, another foundational abortion ruling, does, in fact, address and defend conscientious objection for health-care professionals. The opinion penned by Justice Blackmun states quite clearly that "a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure."⁵

In addition to these implicit and explicit references to the medical professional's right of conscience in abortion law, other more specific legislation has been enacted since the time of *Roe v. Wade* to directly address this issue. Most notably, the Church Amendment was passed in 1973 in response to the *Roe v. Wade* decision. This law protects individuals and institutions that receive public funds from being mandated to provide abortion services. The law both prohibits employment discrimination within these publically funded institutions and protects funding even if that entity refuses to provide abortions. Later, in 1988, Congress enacted the Danforth Amendment, which stated that the Title IX section of the 1972 Education Amendments could not be interpreted as a mandate for individuals or institutions to provide or pay for abortion services. By this time, almost all states had also enacted conscience protecting legislation.⁶ In 1996, the Public Health Service Act was amended

to ensure that government at any level could not discriminate against institutions that refused to undergo or offer abortion training or that refuse to provide or even refer patients for abortion services. Interestingly, in 1997, the Balanced Budget Act was amended to require Medicare and Medicaid programs to allow physicians to inform patients of services not covered under their plans, but protected those programs' right to not pay for services like abortion. This is significant because with this legislation, the government confirmed that conscience protection should be extended to the individual health-care professional, health-care institutions as well as entities that pay for health care. Moreover, in 2004, President Bush signed the Hyde-Weldon Act as a part of a larger budget appropriations bill. This act affirms and extends the protection originally provided by the Church Amendment. In sum, this body of legislation, enacted over the course of twenty years, has gone to great lengths to protect both individual and collective conscience.⁷

Opposition to the Right of Conscience

On one hand it seems that conscience protection is secure and protected by U.S. legislation. However, recent years have seen a shift in the attitude of some toward conscientious objection in health care. Between 2005 and 2011, several legislative attempts have been made to revoke the comprehensive protection of conscience that had previously been afforded in health care. The Access to Legal Pharmaceuticals Act of 2005 sought to require pharmacists to fill emergency contraceptive prescriptions even if that conflicted with their moral or religious beliefs. At its core, this act asserts, "An individual's right to religious belief and worship cannot impede an individual's access to legal prescriptions, including contraception."⁸ In addition, the Freedom of Choice Act, introduced in 2007,

Prohibits a federal, state, or local governmental entity from: (1) denying or interfering with a woman's right to exercise such choices; or (2) discriminating against the exercise of those rights in the regulation or provision of benefits, facilities, services, or information . . . [and] provides that such prohibition shall apply retroactively.⁹

The appearance of these measures on the legislature's docket confirms that there is significant resistance to the exercise of conscience in health care, particularly when it comes to women's access to abortion.

The opposition to conscience stands on a platform with four main points: conscience limits the reproductive choices of women, conscientious objection constitutes sex discrimination, the exercise of conscience by a health-care professional renders a negative value judgment on the patient, and professional ethics demands that medical professionals perform troubling procedures simply because they are a necessary part of their specialty.

First, it is argued that refusing to perform abortion, or other procedures that a health-care professional may find morally illicit, limits the liberty of the patient. As such, allowing medical professionals the right to refuse to participate in such procedures elevates the moral and ethical convictions of the professional above the autonomy rights of patients. Kimberly Moss asserts, “the right of doctors and pharmacists to act within the boundaries of their consciences does not trump that of a woman’s right to adequate health-care and abortive services.”¹⁰ Moss also believes that “federal and state conscience regulations [have upheld] America’s historic practice of restricting women’s access to health care,” and that it is time for the U.S. legislature to ensure that women have guaranteed access to abortive procedures. It is Moss’s position that legislation such as the Hyde-Weldon Act allows the religious beliefs of particular health-care professionals to restrict the reproductive choices of women who seek abortions from those doctors. In sum, Moss is concerned that “In response to pressure from the health community, the federal government has essentially taken the right to choose out of the hands of women and placed it into the hands of the medical staff they have sought for care.”¹¹ Along these same lines, yet taking the argument a step further, Moss argues, “Under the current jurisprudence and the ethical norms of the obstetric and gynecological community, [conscience-protecting] laws may be challenged on constitutional grounds as forms of sex discrimination that violate the norms established by *Roe* and *Casey*.”¹² Therefore, conscience protection not only limits the reproductive freedom of women, it does so in a way that is specifically discriminatory of women.

Another objection to conscience protection proclaims that when a health-care professional refuses to provide the patient with services that the professional finds morally objectionable the professional is not only passing a moral judgment on the procedure but on the patient herself. This, opponents argue, is potentially devastating for the patient and ultimately damages the patient-physician relationship. In arguing that pharmacists should be required to dispense abortifacient or contraceptive drugs, Elizabeth Fenton and Loren Lomasky opine,

It is one thing to decline to do business with someone, quite another to classify her intended action as reprehensible. The judgment implied by rejecting the prescription . . . amounts to humiliation, and it is within the purview of social policy to shield individuals, especially those whose circumstances render them particularly vulnerable, from the infliction of distress. Laws prohibiting hate speech or racial discrimination have that purpose; a requirement to fill all legitimate prescriptions would operate similarly.¹³

Lastly, many argue that health-care professionals choose their careers and specialties fully informed of the types of procedures that are standard to those specialties.¹⁴ Once trained and licensed, these professionals are then bound by a code of professional ethics that demands

that they be willing to perform any and all procedures that are germane to that specialty.¹⁵ Immaculada de Melo-Martin argues that policies written by professional organizations that protect conscience

fail the internal goal of helping create a responsible professional culture, and [thus fail] the external goal of assuring others that [professionals] will meet their professional responsibilities. In fact, such a policy indicates that [professionals] might choose not to fulfill such duties, and that in such cases the professional associations will support this failure.¹⁶

As the influence of this opposition to conscience rights has appeared in proposed legislation, this movement has also influenced policy statements in professional organizations. For example, the American College of Obstetricians and Gynecologists (ACOG) ethics committee issued a committee opinion in 2007 that was reaffirmed in 2010 that recommended certain limitations on conscientious refusal in reproductive medicine.¹⁷ The opinion maintained that ACOG professionals should only follow their conscience if it does not prevent fulfillment of their primary duty to the patient. This article argues that abortion is “standard” care in women’s reproductive medicine and that by not providing abortion services to patients (by either providing or referring the patient) the conscience-led physician is interfering with the patient’s well-being “as they perceive it.”¹⁸ Fulfilling patient requests in order to promote their self-identified sense of well-being is, according to the ACOG ethics committee, primary to the obstetrician’s code of ethics. In addition, this document asserts that conscientious refusal can act as an imposition of religious and moral beliefs on the patient¹⁹ and discusses the potential for conscientious refusal to be inadvertently discriminatory.²⁰

Some might argue that this document is simply an opinion intended to foster thought and discussion on the matter. However, the American Board of Obstetricians and Gynecologists (ABOG), the body that certifies physicians in female reproductive medicine, indicates that one of the grounds for the revocation of a certificate is “violation of ABOG or ACOG rules and/or ethics principles.”²¹ Since the ACOG ethics committee has recommended that patient autonomy should limit conscience in female reproductive medicine, there is now the real potential for professional repercussions to those that decide to exercise conscience in medical practice.

The Cost of Compromising Conscience

After reviewing the tenor of the opposition and its effect on the ethics principles and certification policies of some professional organizations, one might ask if threats to the right of conscience in health care really matter. What is at stake here? Unfortunately, what is at stake is quite serious. For the health-care professionals who practice medicine according to their conscience, their careers are potentially at stake. For

patients who rely on noble physicians for trustworthy care, the quality of the care offered them stands to suffer.

According to a 2009 poll of 2,865 faith-based health-care professionals, 91 percent of faith-based physicians agreed with the statement, “I would *rather stop practicing medicine* altogether than be forced to violate my conscience.”²² Interestingly, what this means is that those who would limit conscience protection would do so under the auspices of protecting patients from discrimination are failing to recognize the discrimination that is posed on health-care professionals when they are forced to ignore their conscience in their practice of medicine. Moreover, if physicians and other health-care workers perceive that they are not at liberty to act out of their personal convictions about what is right and wrong and are not free to treat their patients with the dignity and care that guides the professional to make decisions that they truly believe are in the best interest of the patient, then health care will suffer. In that same poll, 32 percent of faith-based physicians report feeling pressured to refer patients for a procedure that was morally troubling to them and almost 40 percent report that they had experienced discrimination in the workplace based on their moral, ethical, or religious beliefs. One-fifth of faith-based medical students report “not pursuing a career in obstetrics and gynecology” because they feared discrimination or coercion in reproductive medicine.²³ Patients even indicate that having physicians that feel free to follow their conscience is important. In a national poll of 1,000 American adults taken in April through May of 2011, 87 percent of American adults indicate that it is either “very” or “somewhat” important to them “that health-care professionals in the U.S. are not forced to participate in procedures or practices to which they have moral objections.”²⁴ Sixty-two percent of the people participating in this poll opposed the Obama Administration proposal to eliminate conscience protection regulation.²⁵

Therefore, if some proportion of physicians choose not to practice medicine rather than engage in providing certain morally questionable procedures to their patients, there would not only be a strain on the already overworked health-care system, but there would be a significant loss of caring and conscientious professionals available for patients to rely on.

Defending Conscience Beyond Religious Freedom

By what rationale should conscience be protected? Since conscientious refusal in health care is often motivated by religious convictions held by the medical professional, many have argued that the right of conscience is a First Amendment right, a right to free exercise of religion. While this may be a valid claim, many see this as an imposition of health-care workers’ religious preference on their patients.

However, religious freedom is not the only grounds on which conscientious objection is defensible. In fact, there are many other dimen-

sions to the good inherent to the right of conscience that, when articulated, may do more to advance the cause of conscientious refusal than a focus on religious freedom. The most compelling justification for the right of conscience in health care is that it upholds the same individual autonomy offered to pregnant women in the Fourteenth Amendment (as defended in *Roe v. Wade*). Moreover, the right to conscience represents appropriate limits on government paternalism and has historically been upheld as an inalienable right of American citizens. Lastly, and perhaps most critically, the freedom to practice medicine out of one's moral convictions is paramount to maintaining the integrity of health-care professionals and their relationships with patients.

The Fourteenth Amendment of the U.S. Constitution states that government shall not "deprive any citizen of life, liberty, or property without due process of law."²⁶ Ironically, this amendment is often called the "abortion amendment" because the legality of abortion was established on the basis of the "liberty" right of women to decide if they were pregnant or not. This liberty clause constitutionalizes personal autonomy for the American citizen. The critical question here is whether or not personal autonomy as protected by the Fourteenth Amendment extends into the professional practice of medicine. As discussed previously, many believe that it does not. Melo-Martin asserts that once physicians, nurses, or pharmacists exercise autonomy in choosing their profession, they agree to abide by the ethics code of that medical specialty.²⁷ However, Mark Reinzi argues that the right to conscience in health care does fall under the Fourteenth Amendment. Reinzi reminds us that the Fourteenth Amendment protects "fundamental rights and liberties, which are, objectively, deeply rooted in this nation's history and traditions, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed."²⁸ He goes on to argue that conscience is historically rooted and that if conscientious objection were disallowed in medicine both liberty and justice would be sacrificed. Reinzi frames his thesis poignantly: "In short, we know that under the Fourteenth Amendment the government cannot compel a woman to abort her own fetus—the question asked here is, can it force her to abort someone else's?"²⁹ The answer to this question is decidedly, no!

Historically, the State has protected the right of conscience in a variety of different professional contexts. Most notably, the right to conscientious refusal to participate in war has long been protected by the U.S. government.³⁰ Throughout U.S. history, common law has allowed physicians the right to refuse treatment of any patient for just about any reason.³¹ More importantly, the U.S. government and the Supreme Court have upheld the right of health-care professionals to refuse to participate in abortion if they find it morally objectionable or if they believe that it is not in the best interest of their patients (both mother and fetus). When defending the Church Amendment (see previous dis-

cussion) to the House of Representatives, Representative John Heinz said,

Mr. Chairman, freedom of conscience is one of the most sacred, inviolable rights that all men hold dear. With the Supreme Court decision legalizing abortion under certain circumstances, the House must now assure people who work in hospitals, clinics, and other such health institutions that they will never be forced to engage in any procedure that they regard as morally abhorrent.³²

In addition, the Supreme Court ruled in favor of physician conscience in *Washington v. Glucksberg* (1997). While this case was centered around physician-assisted suicide, it is salient to this argument because while the Court acknowledged the suffering of the patient (more severe than the suffering of a woman during an unwanted pregnancy), “they recognized that the legitimacy of other societal values precluded doctors from being forced to relieve the suffering of their patients in this manner.”³³ “This manner” refers to the physician’s role in taking the life of the patient. Since pro-life physicians see the fetus as a patient and as a moral person, abortion would require them to take the life of one of their patients in order to relieve the suffering of their other patient. Perhaps even more salient is the protection afforded to physician’s right of professional judgment in *Roe v. Wade*. While this protection is not explicit in *Roe v. Wade*, it is implicit. Mark Reinzi states this eloquently:

[I]t is clear that the right to an abortion recognized in *Roe* is a right to be free from undue *governmental* interference with one’s efforts to obtain an abortion. Nothing in *Roe* or *Casey* suggests that the right to an abortion includes the right to compel unwilling private health-care providers to provide them. To the contrary, the Court in *Roe* established a right to abortion not only for pregnant women, but also for their physicians. Thus the Court spoke of “the right of the physician” to perform abortions and to administer treatment according to her judgment. Presumably this right to make judgments includes the option to make alternative judgments and decide *not to* perform abortions. In this manner, allowing a physician room to decide not to perform abortions is actually entirely consistent with *Roe*.³⁴

Even more simply, if patients are encouraged to exercise their autonomy in choosing health-care providers and services, it stands to reason that health-care professionals should be free to exercise autonomy in their practice of medicine. One author states this point eloquently, “[f]rom an ethical perspective, exactly as it is wrong to ignore the patient’s right to autonomy by expecting him to conform to the physician’s perspective, in the same way, it would be unfair to treat physicians with a different standard.”³⁵

As mentioned above, patients want to be served by physicians that follow their conscience. If medical professionals felt limited in their free-

dom to practice medicine out of their moral convictions, then the entire nature of the patient-physician relationship would change. In analyzing the effect of limiting conscience in health care on the patient-physician relationship, Azgad Gould suggests that “[e]xpecting physicians to ‘forget’ their values when they encounter a patient who holds a different perspective is morally wrong, as well as unwise, due to the long-term, devastating, and negative consequences on the [patient-physician relationship].”³⁶ Patients need to be able to trust that their physicians will practice medicine out of a deep regard for patient well-being. If a physician truly believes that any particular request does not serve the best interest of the patient, then the physician should be compelled to communicate that to the patient. Conscience as a gut-feeling is empty unless it informs action. For this reason, any patient that wants a virtuous physician cannot expect that physician to make an exception to their convictions simply because the patient is requesting a particular service. The renowned ethicist David Thomasma proposes that in between the medical paternalism and patient autonomy approaches to the patient-physician relationship stands the physician-conscience model in which physicians exercise integrity to provide the highest quality of care to their patient.³⁷ Moreover, in their seminal work *For the Patient's Good: The Restoration of Beneficence in Health Care*, Edmund Pellegrino and David Thomasma propose the beneficence model for the patient-physician relationship that aims to solve the dilemmas presented by undue focus on either physician paternalism or patient autonomy. Their model recognizes that a healthy patient-physician relationship will balance physician paternalism with patient autonomy, but they emphasize that “both doctor and patient must be free to make informed decisions and to act fully as moral agents.”³⁸ Interestingly, Pellegrino and Thomasma’s beneficence model hinges on the moral integrity of the physician. They proclaim that “the good of the patient depends as much on the physician’s character as on his or her ability to make [technical] judgments”³⁹ It is clear that these medical ethicists, who are physicians themselves, identify the importance of upholding physician integrity as a means to maintain high quality patient-physician relationships that protect the patient’s best interest.

Protecting the best interest of the patient requires that health-care agents behave as professionals. The importance of developing professionalism in physicians has been highlighted by the Accreditation Council of Graduate Medical Education in their 2009 Outcome Project in which they emphasize professionalism as a core competency requirement. One definition of medical professionalism identifies the physician as having “autonomy of judgment and authority restrained by their responsibility to use their knowledge and skill.”⁴⁰ Therefore, the distinction between a technician and a professional is not proficiency in a particular set of skills, but the ability to practice that knowledge and skill in the context of sound judgment. Professional judgment must include one’s personal ethical and moral convictions. To eliminate this

element of judgment from the patient-physician relationship relegates the physician to the role of technician rather than professional. A systemic move in this direction across all of medicine would ultimately make the practice of medicine a technical trade rather than a bona-fide profession. This would qualitatively change the practice of medicine and would impact the type of person that seeks to practice that trade. In the long run, failing to protect the exercise of conscience by health-care professionals would fundamentally erode the patient-physician relationship on which medicine is built.

A Few Loose Ends

Earlier, the main objections to the right of conscience in health care were outlined. Defending health-care professionals' right to conscience would be incomplete without addressing these objections directly. The main argument that allowing medical professionals to refuse to participate in abortion elevates the rights of the physician, nurse, or pharmacist above those of the patient and thus limits her reproductive freedom has been refuted above. The government cannot compel a woman's choice as to whether she seeks an abortion, yet neither can it compel a medical professional to be complicit in providing an abortion. Since abortion is an elective procedure, it is incumbent on the patient to find health-care providers who actually provide that service. It is not the responsibility of the medical professional to help her get an abortion.

Moreover, the assertion that physicians and pharmacists will damage the self-esteem of women seeking abortions if they refuse to participate or refer is unfounded. Renee Mirkes views it this way:

There is no direct causal link, then, between a transitioning physician's CO [conscientious objection] and an adverse effect on a patient's health. Just as the feminine consumer will go elsewhere when the first department store fails to carry her preferred brand of clothing without negatively affecting her self-concept as a competent shopper, so a woman wanting contraception or a tubal ligation could go elsewhere in face of her physician's conscientious refusal. And she could do so without suffering setbacks to her health, either psychological or physical.⁴¹

The argument that conscientious refusal to participate in abortions constitutes sex discrimination is simply not logical. Conscience in health care is not simply about abortion. While refusal to participate in abortion is a hot topic right now, conscientious refusal to participate in abortion is really centered on the medical professional's respect for life. For example, a physician who objected to contraception would be as equally unwilling to perform a vasectomy on a man as they would prescribe birth control pills to a woman. Moreover, the physician that is unwilling to perform an abortion would be equally unwilling to assist in the suicide of a male patient. Of course, these examples may falter under the argu-

ment that no single physician prescribes birth control *and* performs vasectomies, or performs abortions *and* would have patients who might request assisted suicide. However, this is precisely the point. The only reason that physicians, nurses, and pharmacists would refuse to provide abortion services only to women is because women are the only patients that ask for abortions! These medical professionals are not refusing to participate in abortion because they have a low view of the rights of women as compared to men, but because they have a high view of the fetus the woman is carrying.

Lastly, the claim that medical professionals choose a set of duties when they select a profession is valid. However, the assertion that life-taking procedures are “standard care” in any medical specialty is not valid. Medicine is aimed at restoring health, not taking life. Moreover, mandating that physicians in any specialty must offer patients free and unfettered access to elective procedures is unfounded. Both abortion and physician-assisted suicide are elective procedures that are rarely medically indicated. Forcing any medical professional (physician, nurse, or pharmacist) to participate (either directly or through referral) in an abortive procedure is akin to requiring all surgeons to perform on-demand cosmetic surgery, even when it endangers the life of the patient. Clearly, this type of mandate flies in the face of the physician’s charge to protect the best interest of patients. In addition, as discussed previously, mandating that medical professionals check their moral convictions at the door of their employment devalues the sense of loyalty and fidelity that patients hold dear in their health-care providers.

Conclusion

It is critically important that health-care professionals maintain the liberty to practice medicine out of their deep convictions. These are the same convictions that likely motivated these individuals to choose to commit their life’s work to the care of others. Simply because a patient decides that they want a particular medical procedure does not, in and of itself, compel action on the part of their physician, nurse, or pharmacist. While it is valid that the patient’s liberty be protected, it is clear that there are many provider options available to the vast majority of patients. For this reason, there is no convincing practical need to limit the right of conscience in health care. There is one common tenet on both sides of this debate: autonomy. The democratic ideal of personal liberty is common ground for all Americans. It is upon this principle that both sides of the conscience debate may be able to see eye to eye. Engaging in this discussion may provide practical means by which to protect the autonomy of the patient while also protecting the freedom of the physician to practice medicine out of their individual moral and ethical convictions.

Notes

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³ Mark L. Reinzi, "The Constitutional Right to Refuse: Roe, Casey, and the Fourteenth Amendment Rights of Healthcare Providers" (2011), 45, <http://ssrn.com/abstract=1749788>.

⁴ *Ibid.*, 36.

⁵ Justice Blackmun, *Opinion of the Court, Supreme Court of the United States; 410 US 179, Doe v. Bolton, Appeal from the United States District Court for the Northern District of Georgia* (January 22, 1973), http://www.law.cornell.edu/supct/html/historics/USSC_CR_0410_0179_ZO.html.

⁶ Reinzi, "The Constitutional Right to Refuse," 38.

⁷ Jody Feder, "The History and Effect of Abortion Conscience Clause Laws," *CRS Report for Congress* (January 14, 2005), <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>.

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¹⁰ Kimberly Moss, "Do No Harm, Unless She Wants an Abortion or Birth Control: The Conscience Movement's Impact on Women's Health," *Texas Journal of Women and the Law* 19 (2010): 174.

¹¹ *Ibid.*, 178.

¹² *Ibid.*, 181.

¹³ Elizabeth Fenton and Loren Lomasky, "Dispensing with Liberty: Conscientious Refusal and the 'Morning-After' Pill," *Journal of Medicine and Philosophy* 30 (2005): 584.

¹⁴ Moss, "Do No Harm, Unless She Wants an Abortion or Birth Control," 185.

¹⁵ Immaculada de Melo-Martin, "Should Professional Organizations Sanction Conscientious Refusals?" *American Journal of Bioethics* 7.6 (June 2007) : 23; Moss, "Do No Harm, Unless She Wants an Abortion or Birth Control," 185.

¹⁶ Melo-Martin, "Should Professional Organizations Sanction Conscientious Refusals?" 24.

¹⁷ ACOG Committee on Ethics. "The Limitations of Conscientious Refusal in Reproductive Medicine," *ACOG Committee Opinion* 385 (2007): 1–6.

¹⁸ *Ibid.*, 3.

¹⁹ Ibid., 1.

²⁰ Ibid., 4.

²¹ American Board of Obstetricians and Gynecologists. *Bulletin for 2008: Maintenance of Certification* (2008): 10.

²² Freedom 2 Care, "April 2009: Two National Polls Reveal Broad Support for Conscience Rights in Health Care," <http://freedom2care.org/learn/page/polls-april-2009>.

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid.

²⁶ United States Constitution, Fourteenth Amendment (July 9, 1868), http://www.usconstitution.net/xconst_Am14.html.

²⁷ Melo-Martin, "Should Professional Organizations Sanction Conscientious Refusals?" 24.

²⁸ Reinzi, "The Constitutional Right to Refuse," 10.

²⁹ Ibid., 5.

³⁰ Ibid., 47.

³¹ Ibid., 29.

³² Ibid., 41.

³³ Teresa Stanton Collett, "Protecting the Healthcare Provider's Right of Conscience," *Center for Bioethics and Human Dignity* (April 26, 2004), <http://cbhd.org/content/protecting-health-care-providers-right-conscience>.

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³⁵ Azgad Gold, "Physician's Right of Conscience-Beyond Politics," *Journal of Law, Medicine and Ethics* 38 (2010): 139.

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³⁷ David C. Thomasma, "Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Patient-Physician Relationship," *Annals of Internal Medicine* 98 (1983): 247.

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⁴⁰ Benedict M. Ashley and Kevin O'Rourke, *Ethics of Healthcare, An Introductory Textbook*, 3rd ed. (Washington D.C.: Georgetown University Press, 2002), 73.

⁴¹ Renee Mirkes. "Protecting the Right of Informed Conscience in Reproductive Medicine," *Journal of Medicine and Philosophy* 33 (2008): 383.